DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **03 - 09**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **July 1, 2003**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2003** **$ 0**
b. FFY 2004 **$ 0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT

10. SUBJECT OF AMENDMENT:

This amendment is in response to Program Memorandum Transmittal #94-9, dated December 1994, adding preprint pages to reflect coverage for home and community care for functionally disabled elderly individuals and personal care services for individuals who are not inpatients or residents of a hospital, nursing facility, intermediate care facility for mentally retarded, or institution for mental disease.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Jason Cooke by Winnie Rutledge

13. TYPED NAME:
Jason Cooke

14. TITLE:
State Medicaid/CHIP Director

15. DATE SUBMITTED:
July 22, 2003

16. RETURN TO:
Jason Cooke
State Medicaid/CHIP Director
Post Office Box 13247
Austin, Texas 78711

Texas (03-09)
Approved: 09/10/03
effective: 07/01/03

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
29 JULY 2003

18. DATE APPROVED:
10 SEPTEMBER, 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 JULY 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
ANDREW A. FREDRICKSON

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR
DIV OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:
See Attachment for Pen & Ink Changes approved by Winnie Rutledge at HHSC on 9/15/03.

FORM HCFA – 179 (07-92)

PEN & Ink changes to CMS Form 179

Transmittal No 03-09

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**
Attachment 3.1-A Page 9, item F	Line Through Provided with Limitations & Indicate (NOT PROVIDED)
Attachment 3.1-A Page 9c	DELETE; replaced with approved # 03-09 Attachment 3.1-A page 10
Appendix 1 to Attachment 3.1-A	Remove Item 24.f pages 52 & 52a and change to Item 26 and renumber pages as Pages 54 & 54a
Appendix 1 to Attachment 3.1-A	Item 24g page 53 – renumber as Page 52
Appendix 1 to Attachment 3.1-A	Item 24h page 54 – renumber as Page 53.
Attachment 3.1- B Page 8, Item F (Personal Care)	Line through Provided With Limitations and Indicate – (NOT PROVIDED)
Appendix 1 to Attachment 3.1 B	Item 23f – Personal Care Services; change to Item 25 and renumber pages from 52 and 52a to Pages 54 & 54a
Appendix 1 to Attachment 3.1 B	Renumber pages 23g Ambulatory Surgical Center Page 53 to Page 52
Appendix 1 to Attachment 3.1B	Renumber pages 23h – Birthing Center Facility Services to Page 53

State: Texas

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A_G to Supplement 2 to Attachment 3.1-A.

__X__ Provided ____ Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

__X__ Provided:
- __X__ State Approved (not physician) Service Plan allowed
- __X__ Services outside the home also allowed
- __X__ Limitations described on Attachment

____ Not Provided.

SUPERSEDES: NONE - NEW PAGE

STATE Texas
DATE REC'D 7-29-03
DATE APPV'D 9-10-03
DATE EFF 7-1-03
HCFA 179 TX 03-09

A

State: Texas

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

____ Provided __X__ Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

__X__ Provided:
- __X__ State approved (not physician) Service Plan Allowed
- __X__ Services outside the home also allowed
- __X__ Limitations described on Attachment

____ Not provided.

STATE Texas
DATE RE[illegible] 7-29-03
DATE A[illegible] 9-10-03
DATE [illegible] 7-1-03
[illegible] TX 03-09

A

SUPERSEDES: NONE - NEW PAGE